		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044818

Facility Name: Elm Brook Health Care & Rehab Centre

Address: 127 W. Diversey Ave. (Number) Elmhurst (City) 60126 (Zip Code)

County: DuPage

Telephone Number: (630)530-5225 **Fax #** (630)530-7775

IDPA ID Number: 36-4351749

Date of Initial License for Current Owners: 18-Apr-2000

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773)604-8112

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/18/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 30-Mar-2001 (Date)
(Type or Print Name) Christopher Vicere
(Title) Chief Financial Officer

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)	125	32,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)	63	16,254	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7		TOTALS	188	48,504	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,308	618	1,662	5,588	8
9	SNF/PED					9
10	ICF	23,120	2,139	1,452	26,711	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,428	2,757	3,114	32,299	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.59%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 18-Apr-2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 18-Apr-2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 1,398

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	216,644	19,519	8,593	244,756		244,756		244,756			1
2	Food Purchase		149,498		149,498	(9,203)	140,295	(110)	140,185			2
3	Housekeeping	176,344	36,024		212,368		212,368		212,368			3
4	Laundry	65,948	17,054	4,404	87,406		87,406		87,406			4
5	Heat and Other Utilities			142,335	142,335		142,335		142,335			5
6	Maintenance	37,488	33,443	22,793	93,724		93,724		93,724			6
7	Other (specify):*											7
8	**TOTAL General Services**	496,424	255,538	178,125	930,087	(9,203)	920,884	(110)	920,774			8
	B. Health Care and Programs											
9	Medical Director			10,941	10,941		10,941		10,941			9
10	Nursing and Medical Records	1,421,236	56,020	154,018	1,631,274		1,631,274		1,631,274			10
10a	Therapy		1,202	7,585	8,787		8,787		8,787			10a
11	Activities	78,164	5,742	1,129	85,035		85,035		85,035			11
12	Social Services	33,357		2,899	36,256		36,256		36,256			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,532,757	62,964	176,572	1,772,293		1,772,293		1,772,293			16
	C. General Administration											
17	Administrative	50,301		119,000	169,301		169,301	(87,166)	82,135			17
18	Directors Fees											18
19	Professional Services			16,256	16,256		16,256	2,156	18,412			19
20	Dues, Fees, Subscriptions & Promotions			44,528	44,528		44,528	(19,339)	25,189			20
21	Clerical & General Office Expenses	193,943	48,348	3,753	246,044		246,044	39,692	285,736			21
22	Employee Benefits & Payroll Taxes			306,019	306,019	9,203	315,222	2,498	317,720			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,710	2,710		2,710	606	3,316			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,874	41,874		41,874		41,874			26
27	Other (specify):*							4,079	4,079			27
28	**TOTAL General Administration**	244,244	48,348	534,140	826,732	9,203	835,935	(57,474)	778,461			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,273,425	366,850	888,837	3,529,112		3,529,112	(57,584)	3,471,528			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre #0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			4,691	4,691		4,691	155	4,846			30
31	Amortization of Pre-Op. & Org.							3,012	3,012			31
32	Interest			36,352	36,352		36,352	162,276	198,628			32
33	Real Estate Taxes			30,360	30,360		30,360		30,360			33
34	Rent-Facility & Grounds			552,500	552,500		552,500	(65,774)	486,726			34
35	Rent-Equipment & Vehicles			5,097	5,097		5,097		5,097			35
36	Other (specify):*											36
37	**TOTAL Ownership**			629,000	629,000		629,000	99,669	728,669			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,209	15,039	85,248		85,248		85,248			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,756	72,756		72,756		72,756			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		70,209	87,795	158,004		158,004		158,004			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,273,425	437,059	1,605,632	4,316,116		4,316,116	42,085	4,358,201			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,785)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,895)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	63,980		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 63,980		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 42,085		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Elm Brook Health Care & Rehab Centre

ID# 0044818

Report Period Beginning: 4/18/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
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71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Elm Brook Health Care & Rehab Centre **#** 0044818 **Report Period Beginning:** 4/18/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(110)	0	0	0	0	0	0	0	0	0	0	(110)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(110)	0	0	0	0	0	0	0	0	0	0	(110)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(87,166)	0	0	0	0	0	0	0	0	0	(87,166)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,156	0	0	0	0	0	0	0	0	0	2,156	19
20	Fees, Subscriptions & Promotions	(21,785)	1,146	0	0	0	0	0	0	0	0	0	(20,639)	20
21	Clerical & General Office Expenses	0	39,692	0	0	0	0	0	0	0	0	0	39,692	21
22	Employee Benefits & Payroll Taxes	0	2,498	0	0	0	0	0	0	0	0	0	2,498	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	606	0	0	0	0	0	0	0	0	0	606	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	4,079	0	0	0	0	0	0	0	0	0	4,079	27
28	**TOTAL General Administration**	(21,785)	(36,989)	0	0	0	0	0	0	0	0	0	(58,774)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,895)	(36,989)	0	0	0	0	0	0	0	0	0	(58,884)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 **Report Period Beginning:** 4/18/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	155	0	0	0	0	0	0	0	0	0	155	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	(11,128)	0	0	0	0	0	0	0	0	0	(11,128)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(10,973)	0	0	0	0	0	0	0	0	0	(10,973)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(21,895)	(47,962)	0	0	0	0	0	0	0	0	0	(69,857)	45

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Salary - Cynthia and Laurence	$	Lancaster, Ltd.	100.00%	$ 26,077	$ 26,077	1
2	V		27	P/R Taxes-Cynthia and Laurence		Lancaster, Ltd.	100.00%	728	728	2
3	V		17	Management Fee Income	119,000	Lancaster, Ltd.	100.00%		(119,000)	3
4	V		19	Professional Services		Lancaster, Ltd.	100.00%	2,156	2,156	4
5	V		21	Office Expenses		Lancaster, Ltd.	100.00%	2,479	2,479	5
6	V		22	Employee Benefits		Lancaster, Ltd.	100.00%	2,498	2,498	6
7	V		24	Education and Seminars		Lancaster, Ltd.	100.00%	606	606	7
8	V		17	Administrative Consultant		Lancaster, Ltd.	100.00%	5,757	5,757	8
9	V		32	Interest	36,352	Lancaster, Ltd.	100.00%	25,224	(11,128)	9
10	V		30	Depreciation		Lancaster, Ltd.	100.00%	155	155	10
11	V		21	Salaries - Clerical		Lancaster, Ltd.	100.00%	37,213	37,213	11
12	V		27	P/R Taxes - Clerical		Lancaster, Ltd.	100.00%	3,351	3,351	12
13	V		20	Advertising		Lancaster, Ltd.	100.00%	1,146	1,146	13
14	Total				$ 155,352			$ 107,390	$ * (47,962)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Cynthia Chow	Officer	Administrative	33.34%	See Attached	2	3.00%	Lancaster	$ 11,077	17-7	1
2	Laurence Zung	Officer	Administrative	33.33%	See Attached	2	4.17%	Lancaster	15,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 26,077		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 3520 W. Thorndale Ave.
City / State / Zip Code: Chicago, IL. 60659
Phone Number: (773)539-8181
Fax Number: (773)539-8133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Cynthia Chow	Hours Worked	65	7	$ 360,000	$ 360,000	2	$ 11,077	1
2	27	Cynthia Chow	Hours Worked	65	7	10,054	0	2	309	2
3	17	Laurence Zung	Hours Worked	48	7	360,000	360,000	2	15,000	3
4	27	Laurence Zung	Hours Worked	48	7	10,054	0	2	419	4
5										5
6										6
7	19	Professional Services	Management Fees	1,455,000	7	26,361	0	119,000	2,156	7
8	21	Office Expenses	Management Fees	1,455,000	7	30,313	0	119,000	2,479	8
9	22	Employee Benefits	Management Fees	1,455,000	7	30,548	0	119,000	2,498	9
10	24	Education and Seminars	Management Fees	1,455,000	7	7,408	0	119,000	606	10
11	17	Administrative Consultant	Management Fees	1,455,000	7	70,392	0	119,000	5,757	11
12	32	Interest	Management Fees	1,455,000	7	308,413	0	119,000	25,224	12
13	30	Depreciation	Management Fees	1,455,000	7	1,898	0	119,000	155	13
14	21	Salaries - Clerical	Management Fees	1,455,000	7	454,998	454,998	119,000	37,213	14
15	27	P/R Taxes Clerical	Management Fees	1,455,000	7	40,971	0	119,000	3,351	15
16	20	Advertising	Management Fees	1,455,000	7	14,009	0	119,000	1,146	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,725,420	$ 1,174,998		$ 107,390	25

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Lancaster, Ltd.	X		Working Capital	interest only	4-18-00		96,644	demand	9.0000	36,352	6
7												7
8												8
9	TOTAL Facility Related						$	$ 96,644			$ 36,352	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 96,644			$ 36,352	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 **Report Period Beginning:** 4/18/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	30,360	2
3. Under or (over) accrual (line 2 minus line 1).	$	30,360	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	30,360	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 21,366
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 3,012
4. Dates Incurred: 18-Apr-2000

Nature of Costs: Organization costs associated with the purchase of the facility.
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$	$	$	$		$	37
38	Current Year Purchases	31,274	4,846	4,846			4,846	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 31,274	$ 4,846	$ 4,846	$		$ 4,846	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 31,274	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 4,846	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 4,846	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,846	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: York Convalescent Center ***an unrelated entity***

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			18-Apr-00	$ 486,726			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 486,726 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 18-Apr-2000
Ending 17-Apr-2016

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 699,924
13.	/2002	$ 710,217
14.	/2003	$ 721,832

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 5,097 Description: "IOS Capital" copy machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 4,305	$		$ 4,305	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			654			654	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			10,080			10,080	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				50,727		50,727	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	***Medical Supplies***	39-2					6,986		6,986	
	Other (specify): **Specialty Bed**	39-2					12,497		12,497	13
14	TOTAL			$		$ 15,039	$ 70,209		$ 85,248	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (59,913)	$ (59,913)	1
2	Cash-Patient Deposits	29,589	29,589	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	779,160	779,160	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,177	45,177	6
7	Other Prepaid Expenses	6,615	6,615	7
8	Accounts Receivable (owners or related parties)	96,644	160,655	8
9	Other(specify): **Due from Prior Owner**	25,317	25,317	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 922,590	$ 986,601	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	31,274	31,274	16
17	Accumulated Depreciation (book methods)	(4,691)	(4,691)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,366	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,012)	20
21	Restricted Funds			21
22	Other Long-Term Assets (sp **Option deposit**		1,880,000	22
23	Other(specify): *Construction in Progress*	3,900	4,955	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 30,483	$ 1,929,892	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 953,073	$ 2,916,493	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 113,321	$ 113,321	26
27	Officer's Accounts Payable	1,050,000	1,050,000	27
28	Accounts Payable-Patient Deposits	29,589	29,589	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	363,156	363,156	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,308	14,308	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Employees' Taxes Withheld**	17,273	17,273	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,587,647	$ 1,587,647	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		2,075,362	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,075,362	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,587,647	$ 3,663,009	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (634,574)	$ (746,516)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 953,074	$ 2,916,493	48

***(See instructions.)**

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(634,574)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (634,574)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (634,574)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,775,233	1
2	Discounts and Allowances for all Levels	(241,663)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,533,570	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	59,955	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 59,955	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,820	17
18	Sale of Supplies to Non-Patients	2,271	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	27,982	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 87,073	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Vending Commissions **	944	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 944	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,681,542	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	930,087	31
32	Health Care	1,772,293	32
33	General Administration	826,732	33
	B. Capital Expense		
34	Ownership	629,000	34
	C. Ancillary Expense		
35	Special Cost Centers	85,248	35
36	Provider Participation Fee	72,756	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,316,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	(634,574)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (634,574)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **cash basis taxpayer.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,392	1,456	$ 43,849	$ 30.12	1
2	Assistant Director of Nursing	1,341	1,487	40,685	27.36	2
3	Registered Nurses	13,977	15,944	337,480	21.17	3
4	Licensed Practical Nurses	17,840	18,901	335,443	17.75	4
5	Nurse Aides & Orderlies	53,065	56,483	646,009	11.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	6,003	6,604	78,164	11.84	10
11	Social Service Workers	2,153	2,414	33,357	13.82	11
12	Dietician					12
13	Food Service Supervisor	1,228	1,342	21,173	15.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,339	19,806	195,471	9.87	15
16	Dishwashers					16
17	Maintenance Workers	2,641	2,955	37,488	12.69	17
18	Housekeepers	18,833	19,945	176,344	8.84	18
19	Laundry	5,960	6,548	65,948	10.07	19
20	Administrator	1,318	1,576	50,301	31.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,594	14,037	193,943	13.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	805	861	17,770	20.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	157,489	170,359	$ 2,273,425 *	$ 13.34	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	260	$ 8,593	1-3	35
36	Medical Director	219	10,941	9-3	36
37	Medical Records Consultant	68	2,808	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	1,316	10-3	39
40	Physical Therapy Consultant	217	7,585	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	1,129	11-3	44
45	Social Service Consultant	97	2,899	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	987	$ 35,271		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,701	$ 54,731	10-3	50
51	Licensed Practical Nurses	258	9,753	10-3	51
52	Nurse Aides	4,345	85,410	10-3	52
53	TOTAL (lines 50 - 52)	6,304	$ 149,894		53

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Irene Glass - beg. Aug. 2000	Administrator	N/A	$ 19,650
Rani Srinivas Rao - thru Aug. 2000	Administrator	N/A	30,651
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 50,301

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 119,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 119,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Tax Consult	$ 911
Joseph Panarese	Legal Fees	378
Winston & Strawn	Legal Fees	300
HealthData Systems, Inc.	Data Processing	12,867
Computer Training	Data Processing	1,800
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,256

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,416
Unemployment Compensation Insurance	19,845
FICA Taxes	164,063
Employee Health Insurance	41,697
Employee Meals	9,203
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits-Other	43,436
Uniforms Allowance	8,215
Retirement Plan Contributions	6,909
Holiday	2,438
Lancaster allocation	2,498
TOTAL (agree to Schedule V, line 22, col.8)	$ 317,720

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	14,224
Health Care Worker Background Check	
(Indicate # of checks performed 45)	542
Promotional Advertising	20,639
Dues & Subscriptions	5,772
Licenses and Fees	3,150
Elm Brook Assoc. allocation	1,300
Lancaster allocation	1,146
Less: Public Relations Expense	(20,639)
Non-allowable advertising	(1,146)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 25,189

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	735
Seminar Expense	1,975
Lancaster allocation	606
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,316

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 Report Period Beginning: 4/18/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Elm Brook Health Care & Rehab Centre # 0044818 **Report Period Beginning:** 4/18/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Il. Council on Long-Term Care = $5,273

(3) Did the nursing home make political contributions or payments to a politica
action organization? no If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 years

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 0 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ 72,756
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? no For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ 9,203 Has any meal income been offset against
related costs? no Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? no If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? N/A
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.